Ontario

Ministry of Health and Long-Term Care

Inspection Report under the *Long-Term Care Homes Act, 2007*

Ministère de la Santé et des Soins de longue durée

Rapport d'inspection prévue sous *la Loi de 2007 sur les foyers de soins de longue durée*

Long-Term Care Homes Division
Long-Term Care Inspections Branch

Division des foyers de soins de longue durée
Inspection de soins de longue durée

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Report Date(s) / Date(s) du apport	Inspection No / No de l'inspection	Log # / No de registre	Type of Inspection / Genre d'inspection
Mar 25, 2019	2019_560632_0008	002426-19	Critical Incident System

Licensee/Titulaire de permis

Park Lane Terrace Limited
284 Central Avenue LONDON ON N6B 2C8

Long-Term Care Home/Foyer de soins de longue durée

Park Lane Terrace
295 Grand River Street North PARIS ON N3L 2N9

Name of Inspector(s)/Nom de l'inspecteur ou des inspecteurs

YULIYA FEDOTOVA (632)

Inspection Summary/Résumé de l'inspection

The purpose of this inspection was to conduct a Critical Incident System inspection.

This inspection was conducted on the following date(s): March 13, 14, 15, 18, 19, 2019.

The following intake was completed in this Critical Incident System (CIS) inspection:

log #002426-19 was related to prevention of abuse and neglect, nutrition and hydration.

During the course of the inspection, the inspector(s) spoke with the Executive Director (ED), the Director of Clinical Services (DCS), the Resident Assessment Instrument (RAI) Co-ordinator, Personal Support Workers (PSWs), Registered Nurses (RNs), Registered Practical Nurses (RPNs), Dietary Aids (DAs), residents and their families.

The following Inspection Protocols were used during this inspection:
Nutrition and Hydration
Prevention of Abuse, Neglect and Retaliation

During the course of this inspection, Non-Compliances were issued.
- **1 WN(s)**
- **1 VPC(s)**
- **0 CO(s)**
- **0 DR(s)**
- **0 WAO(s)**

During the course of this inspection, Administrative Monetary Penalties (AMP) were not issued.
- **0 AMP(s)**

NON-COMPLIANCE / NON - RESPECT DES EXIGENCES	
Legend WN – Written Notification VPC – Voluntary Plan of Correction DR – Director Referral CO – Compliance Order WAO – Work and Activity Order AMP – Administrative Monetary Penalty	Legendé WN – Avis écrit VPC – Plan de redressement volontaire DR – Aiguillage au directeur CO – Ordre de conformité WAO – Ordres : travaux et activités AMP – Administrative Monetary Penalty
Non-compliance with requirements under the Long-Term Care Homes Act, 2007 (LTCHA) was found. (a requirement under the LTCHA includes the requirements contained in the items listed in the definition of "requirement under this Act" in subsection 2(1) of the LTCHA). The following constitutes written notification of non-compliance under paragraph 1 of section 152 of the LTCHA. AMP (s) may be issued under section 156.1 of the LTCHA	Le non-respect des exigences de la Loi de 2007 sur les foyers de soins de longue durée (LFSLD) a été constaté. (une exigence de la loi comprend les exigences qui font partie des éléments énumérés dans la définition de « exigence prévue par la présente loi », au paragraphe 2(1) de la LFSLD. Ce qui suit constitue un avis écrit de non-respect aux termes du paragraphe 1 de l'article 152 de la LFSLD. AMP (s) may be issued under section 156.1 of the LTCHA

WN #1: The Licensee has failed to comply with O.Reg 79/10, s. 26. Plan of care

Specifically failed to comply with the following:

s. 26. (3) A plan of care must be based on, at a minimum, interdisciplinary assessment of the following with respect to the resident:
21. Sleep patterns and preferences. O. Reg. 79/10, s. 26 (3).

Findings/Faits saillants :

1. The licensee failed to ensure that a plan of care was based on, at a minimum, interdisciplinary assessment of the following with respect to the resident: 21. Sleep patterns and preferences.

A. A Critical Incident System (CIS) Report log #002426-19 (CI 2779-000006) was submitted to the Ministry of Health and Long-Term Care (MOHLTC) in January 2019, identified an incident on an identified date in January 2019.

In March 2019, PSW #107 indicated that on an identified date in January 2019, resident #115 was sleeping during breakfast and was offered identified interventions after they woke up. Review of Multidisciplinary Dining Room Policy indicated that residents were to be served meals in the dining room unless their needs were better met in another location, according to the residents' plans of care. In March 2019, RN #110 indicated that resident's plan of care was to be updated by registered staff according to resident's sleeping pattern. Review of written plan of care for resident #115 (last reviewed in October 2018) indicated no interventions for the resident's sleep patterns and preferences, which was acknowledged by the ED and the DCS in March 2019.

The licensee did not ensure that the plan of care for resident #115 was based on, at minimum, interdisciplinary assessment of sleep patterns and preferences.

B. In March 2019, PSW #107 indicated that on an identified date in January 2019, resident #117 was sleeping during breakfast and was offered identified interventions after they woke up. Review of Multidisciplinary Dining Room Policy indicated that residents were to be served meals in the dining room unless their needs were better met in another location, according to the residents' plans of care. In March 2019, RN #110 indicated that resident's plan of care was to be updated by registered staff according to resident's sleeping pattern. Review of written plan of care for resident #117 (last reviewed in November 2018) indicated no interventions for the resident's sleep patterns and preferences, which was acknowledged by the ED and the DCS in March 2019.

The licensee did not ensure that the plan of care for resident #117 was based on, at minimum, interdisciplinary assessment of sleep patterns and preferences.

C. In March 2019, PSW #107 indicated that on an identified date in January 2019, resident #116 was sleeping during breakfast and was offered identified interventions after

they woke up. Review of Multidisciplinary Dining Room Policy indicated that residents were to be served meals in the dining room unless their needs were better met in another location, according to the residents' plans of care. In March 2019, RN #110 indicated that resident's plan of care was to be updated by registered staff according to resident's sleeping pattern. Review of written plan of care for resident #116 (last reviewed in October 2018) indicated no interventions for the resident's sleep patterns and preferences, which was acknowledged by the ED and the DCS in March 2019.

The licensee did not ensure that the plan of care for resident #116 was based on, at minimum, interdisciplinary assessment of sleep patterns and preferences. [s. 26. (3) 21.]

Additional Required Actions:

VPC - pursuant to the Long-Term Care Homes Act, 2007, S.O. 2007, c.8, s.152(2) the licensee is hereby requested to prepare a written plan of correction for achieving compliance and ensuring that a plan of care is based on, at a minimum, interdisciplinary assessment of the following with respect to the resident sleep patterns and preferences, to be implemented voluntarily.

Issued on this 4th day of April, 2019

Signature of Inspector(s)/Signature de l'inspecteur ou des inspecteurs

Original report signed by the inspector.